CITY OF SAINT PAUL

EMPLOYEE'S SAFETY REPORT — INJURY OR AGGRAVATION

EMPLOYEE MUST SUBMIT THIS REPORT WITHIN 24 HOURS OF WORK-RELATED INJURY OR AGGRAVATION.

DEPARTMENT_____ **DIVISION**_____ **ACTIVITY CODE**_____

1 Name of injured employee_____ Phone: Home_____ Work_____

2 Home address (including city and zip code)_____

3 Date of Birth_____ ☐ Male ☐ Female Marital status_____ Soc. Sec. #_____

4 Job title_____ Salary $_____ ☐ Hourly ☐ Biweekly

5 Job Status ☐ Full time ☐ Part time ☐ Temporary Do you have another job? ☐ No ☐ Yes

6 If YES, provide company name, your position and salary: _____

_____

INJURY INFORMATION

7 Date injured_____ Time_____ Date reported to supervisor_____ Was time lost from work? ☐ No ☐ Yes

First day lost (date)_____ Return to work, actual or expected (date)_____

8 Was medical treatment given? ☐ No ☐ Yes Provide name and address of physician and/or hospital:

_____

9 Nature of injury (cut, sprain, burn, etc.)_____

10 Part/parts of body injured_____

11 Exact location of accident_____

12 Describe accident in detail_____

_____

_____

_____

_____

_____

13 If aggravation, what caused resumption of symptoms?_____

_____

14 Did you have a prior injury to this portion of the body? ☐ No ☐ Yes When?_____

Did prior injury or disability contribute to this injury? ☐ No ☐ Yes Explain?_____

_____

15 Witnesses (names and phone numbers)_____

_____

I certify that all statements in this report are true. _____ **Date**_____

(Employee Signature)

Supervisor's comments: _____

Supervisor's signature: _____

WHITE--Workers' Compensation Administrator YELLOW--Department PINK--Supervisor